

ACTS Complaint/Incident Investigation Report**PROVIDER INFORMATION**

Name: RIDGEVIEW INSTITUTE MONROE

Address: 709 BREEDLOVE DRIVE

City/State/Zip/County: MONROE, GA, 30655, WALTON

Telephone: (678) 635-8730

License #: 147-720

Type: HOSP-P

Medicaid #:

Administrator: HEIDI HILLERY

INTAKE INFORMATION

Taken by - Staff: (b)(6) (b)(7)c

Location Received: HFRD COMPLAINT INTAKE & TRIAGE

Intake Type: Complaint

Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA, CLIA

External Control #:

SA Conta

(b)(6) (b)(7)c

RO Contact:

Responsible Team: HFRD HC- ACUTE CARE

Source: Other

Received Start: 03/06/2018 At 10:07

Received End: 03/09/2018 At 10:07

Received by: E-Mail

State Complaint ID:

CIS Number:

COMPLAINANTS

Name	Address	Phone	Email
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(b)(6) (b)(7)c

RESIDENTS/PATIENTS/CLIENTS - No Data**ALLEGED PERPETRATORS - No Data****INTAKE DETAIL**

Date of Alleged

Time:

Shift:

Standard Notes: The administration and corporate leaders of Ridgeview Institute in Monroe, Georgia has unsafe practice for patient and staff safety.

At times, one nurse may have 15 to 20+ patients to provide patient care to, administer medications, admit and discharge patients, chart on every patient, check for new orders and transcribe them, patient rounding when the mental health techs (MHT) are off the unit with other patients, and the many other aspects of nursing care. At times, there is one MHT, on a good day two MHT 's, with same number patients as the nurse. MHT duties include 15 minute patient rounds, leading groups, taking vital signs, observing line-of-sight and 1:1 patients, taking patients to and from the cafeteria, taking patients out to smoke, laundry, assisting with admissions, checking patient belongings, performing safety checks and more.

There are other disciplines in the unit at times, but they are not providing any type of patient care, making patient rounds, or performing safety checks. The nursing supervisor is over four units, does intake referrals, staffing, scheduling, provide breaks, help with admissions, help with crisis situations and all the other duties required.

The population of patients can be violent in nature, have psychosis, detoxing from drugs and/or alcohol, be suicidal or homicidal, and have other mental health illnesses.

There have been injured staff members and other patients because of violent patients having been admitted without

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proper staffing to monitor or care for them properly to keep ill effects happening. Administration and corporate leaders allow admission to continue even though there is already an unsafe nurse/MHT to patient ratio.

nurse/MHT to patient ratio.

There was a recent patient suicide at the facility which more likely could have been avoided had there been better staffing or a decreased number of patients for the nursing staff available. On this unfortunate day, there was 19 patients, two nurses and one MHT working on a unit. The one MHT was to do all the duties mentioned above, alone. The nurses had all their duties as mentioned above to perform. The supervisor, again, was performing her many duties mentioned above. There were three other staff on the unit at the time, but they were not assisting the nursing staff. Because of the lack of nursing staff, patient rounding could not be performed as needed by the one MHT working which lead to the tragedy of a loss of life.

Because of the stress from the unsafe environment, many staff members are leaving which causes the nursing staff shortage even greater.

An angry and very concerned individual.

MC

2/28/18

I have an update on my concern with Ridgeview Institute - Monroe

Sunday, February 18, 2018, the facility operated with critically low staffing. The unit I will reference is their intermediate/dual diagnosis unit. This particular unit had 23 patients on the onset of the 7p - 7a shift staffed with one RN and 2 MHT 's. There was an admission making the staff/patient ratio even more critical. In my prior email, I gave an example of the duties of the RN 's and MHT 's for the shift. Again, all their responsibilities were expected while trying to assure patient care and safety. Also, on this given day, there were two 1:1 patients that were in the same room with one sitter instead of two. The other three units were staffed in the same critical manner.

This is only one particular day I am referring to. There have been many days like this since my initial email. I am advocating for patients and staff. Since my initial email, a staff member was hit in the head with a chair by an adolescent patient. His injuries included a laceration below his eye requiring seven sutures and a broken nose.

I am not a disgruntled ex-employee, I am a person concerned about lives and safety. There will more hurt and/or deaths of patients and/or staff if something is not done about this facility.

Sincerely (b)(6) (b)(7)c

Since writing my last update, I have been informed, by a friend remaining at Ridgeview, the new CNO informed the supervisors there is no reason that there cannot be 30 patients with one nurse and two techs. Also, the supervisors were told if anything happens on the floor they will held responsible for any injuries to patients or staff, accidents, or

3/7/18 9:45 am- Called the complainant and left a VM msg.

3/7/18 AM- Verbally informed the Prog Mgr of this potential (b)(6) (b)(7)c

3/8/18 12:20 pm- Complainant returned call and reported the following:

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Staffing in the hospital is extremely minimal, and Nurses and MHTs are forced to provide minimal and unsafe care and monitoring to patients who are often unpredictable, violent. Patients hurt staff and other patients. Staff have been unable to provide continuous 1-1 monitoring.

In late January-early February 2018, a patient who had been threatening suicide for days, including that day, was found hanging by her hoodie in the bathroom of her room. The patient had been assigned a continuous Line of Sight (LOS) monitoring level which required that the patient remain in continuous eyesight of staff. The doctor ordered that the patient be allowed to take a nap, and the patient was allowed to go into her room to nap. However, her monitoring level of LOS was not changed, and was not maintained during this time. The patient was found hanging by her hoodie at around 5:00 pm, and was dead. It was determined that she hadn't been checked on for 45 minutes. The complainant reported that she did not know the patient's name, but would try to get it and call or email it to the department when she gets it.

The complainant reported that the facility has been continuously short staffed and the special monitoring levels such as 1:1 and LOS cannot be done. However, despite this, the facility continues to admit patients, and patients continue to need special observation levels to protect them. The complainant reported that the new DON has informed staff that they are cutting staffing (decreasing staff:patient ratio) even more now. Complainant reported that she is concerned that further deaths and injuries will occur.

NOTE- Triaged as an IJ. COPs Nursing, Patient rights. (b)(6) (b)(7)c

Extended RO Notes:

Extended CO Notes:

ALLEGATIONS

Category: Resident/Patient/Client Rights

Subcategory: Other

Seriousness: Critical

Findings: Substantiated: No deficiencies related to the alleg are cited

Details: The complainant alleged that the facility failed to protect the patients' right to care in a safe environment. Specifically, the complainant alleged that the facility lacked sufficient staff to maintain/provide a physician ordered continuous monitoring of a patient, and as a result, the patient committed suicide.

An unannounced on-site visit was made to the facility on 03/12/18 and 03/13/18 by five (5) qualified surveyors to investigate this complaint. The complainant was interviewed on 03/08/18 by a representative of the Complaint and Incident Investigation Unit of the Healthcare Facility Regulation Division.

The facility's Quality Data was reviewed from January 1, 2018 through March 12, 2018. This data included: patients found with contraband, patient on patient touching or kissing, a drawstring in pants, damage to property, patient on patient hitting with minor to no injuries, self-injurious behavior, patients inflicting injuries to staff, and one (1) hanging. The Quality Data and/or the sampled medical records revealed:

--Patient #1 was admitted on 01/11/18 with a diagnosis of Major Depression Disorder (MDD) and Suicidal Ideations (SI). The patient was admitted on a 1013 (Georgia's Law that allows a patient to be held involuntarily when the patient presents a danger to self or others). The physician's admission orders revealed the patient was placed on every 15 minutes monitoring and daily suicide risks assessments. Physician orders revealed an order on 01/19/18 for the patient to be moved to a room across from the nurses' station (this order was never carried out), and on 01/20/18 the physician wrote an order for the patient to be allowed to go to his/her room (#208) for 30 minutes.

Nursing documentation revealed the patient denied suicidal thoughts on 01/15/18, 01/16/18, and 01/17/18, passively endorsed suicidal thoughts on 01/18/18, and denied suicidal thoughts on 01/19/18 and 01/20/18. The Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from the time of admission until the time the patient was found hanging from the his/her bathroom door at 5:15 p.m. on 01/20/18. Review of the Code Blue sheet revealed the patient was found hanging from the bathroom door by a sweat shirt at 5:15 p.m. during the every 15 minutes rounds. The Code Blue sheet revealed cardiopulmonary resuscitation (CPR - chest compressions and assisted breathing) was initiated at 5:16 p.m. The Code Blue sheet indicated that 911 was called at 5:17 p.m. and that an intravenous (inserted into a vein) line was placed at 5:22 p.m. and a bag of normal saline (fluid) was hung. This form revealed the patient had no pulse and no respirations when found. The form indicated that when the ambulance attendants removed the patient from the facility the patient's heart rate was in the 160s (normal 60-100). Nurses' notes and a note from the Chief Executive Officer (CEO #13) revealed the physician and the patient's family were notified.

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The facility's video recording was reviewed with the Director of Risk Management/Performance Improvement (DRMPI #2) on 01/13/18 at 1:00 p.m. in the CEO's office. The video record was dated 01/20/18 and time stamped 4:00 p.m. The recording showed the Adult Intermediate hall from the end of the hallway facing down toward the Nurses' Station and Day Room, nurse (registered nurse RN #11) is seen in the hallway. Doors to room number 202 and 203 are observed to be open. At 4:04 p.m. the patient is seen exiting the day room heading toward his/her room (208), the patient passes RN #11 and they briefly speak. The patient is seen entering his/her room. There is no monitoring of the patient from 4:04 p.m. until 5:12 p.m. when the Mental Health Technician (MHT #12) enters the patient's room. MHT #12 is observed coming out of the room and then numerous staff enter the room. At 5:14 p.m. the Nurse Supervisor (#3) is seen running down the hall to the patient's room and then running to call 911. At 5:16 p.m. a staff member arrives with the crash cart. At 5:18 a physician is seen entering the patient's room and leaving within 30 seconds. At 5:22 p.m. the police arrive. At 5:24 p.m. the Emergency Medical Service (EMS) team arrive. At 5:36 p.m. EMS leave with the patient on a stretcher with an Automatic Chest Compression Device (delivers chest compressions) attached to the patient. In addition, the EMS are observed bagging (rescue respirations) the patient.

The CEO (#13) entered his/her office on 01/13/18 at 1:30 p.m. while surveyors were watching the above video. The CEO stated and confirmed that the patient had not been monitored and stated that he/she had watched the video right after the occurrence and found that the MHT (#12) assigned to monitor the patient had been sitting at the nurses' desk for over an hour and had not monitored the patient. The CEO explained that the MHT (#12) and RN (#11) had been immediately terminated for not following facility policy.

--Patient #2 was admitted on 02/01/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/04/18, documentation revealed the patient was throwing chairs in the day room and that a staff member (#4) was injured. An order was received to place the patient in a hold and move the patient to the seclusion room for up to two (2) hours. Documentation revealed the patient was placed in a five (5) minute hold and then placed in seclusion for 31 minutes. Documentation revealed the patient was monitored every 15 minutes while in seclusion, received an assessment after being removed from seclusion, and that a face to face was completed within one (1) hour after the patient was removed from seclusion. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #3 was admitted on 01/30/18 with a diagnosis of Bipolar Disorder (mood swings from extreme high to extreme low) and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/04/18, documentation revealed the patient was throwing chairs in the day room and that a staff member (#4) was injured. An order was received to place the patient in a hold. Documentation revealed the patient was placed in the hold and de-escalated per physician orders and facility policy. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/06/18.

--Patient #4 was admitted on 12/20/17 with a diagnosis of unspecified psychosis (loss of touch with reality), aggression, and inappropriate sexual behavior. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/02/18, documentation revealed the patient was agitated, being sexually aggressive toward peers, and hit a staff member. Documentation revealed an order was received to give the patient Haldol for sedation and to place the patient in seclusion for up to 30 minutes. Nurses' notes revealed the physician's orders were carried out and that the patient was monitored while in seclusion. In addition, the Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from admission to discharge on 01/31/18.

---Patient #5 was admitted on 01/13/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/19/18, documentation revealed the patient was found to have scratched his/her thighs with a plastic spoon that the patient reported finding. Documentation revealed the physician ordered the patient to be "blocked from room for 24 hours" (not allowed in his/her room) due to self-injurious behavior. Documentation revealed the patient's belongings were searched during this time. In addition, the Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from admission to discharge on 01/22/18.

--Patient #6 was admitted on 01/23/18 with a diagnosis of Attempted Suicide and Overdose. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/29/18, documentation revealed the patient hit a wall. An order was received to place the patient on line of sight (kept within sight at all times) for 24

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hours. Documentation revealed the patient was monitored as ordered. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #7 was admitted on 01/24/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/02/18, documentation revealed the patient hit a peer. Physician orders and monitoring sheets revealed the patient was placed on close observation. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #8 was admitted on 02/01/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 03/04/18 documentation revealed the patient knocked a printer off a desk and that the printer hit a staff member in the back. Physician orders and the medication administration record revealed the patient was medicated with Haldol (medication used to calm patients) as ordered. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #9 was admitted on 01/02/18 with a diagnosis of Bipolar. Physician orders revealed the patient was placed on routine 15 minutes observation. Documentation revealed that the patient was found to have a drawstring in his/her pants and that the drawstring was removed for safety. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #10 was admitted on 12/28/17 with a diagnosis of Bipolar. Physician orders revealed the patient was placed on routine 15 minutes observation. Documentation revealed the patient was observed salivating and having difficulty breathing, staff performed "CPR" (Heimlich maneuver) and the patient coughed up a yellow magic marker cap. Documentation revealed the patient and his/her room was then searched for contraband. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

During the entrance on 03/12/18 at 10:30 a.m. in the Conference Room, the CEO (#13) explained that he/she had been with the facility since 01/08/18. The Chief Nursing Officer (CNO #1) explained that he/she had been with the facility for two (2) weeks, and the DRMPI (#2) stated he/she had been with the facility for about one (1) month. The CEO and CNO explained that nursing staff work 12-hour shifts, the shifts are from 7:00 a.m. to 7:00 p.m. (day shift) and 7:00 p.m. to 7:00 a.m. (night shift). In addition, the CEO and CNO explained that the facility has four (4) units which include the following:

- Adolescent Unit (12 to 17 years old or 18 years old and still in high school) which has 20 beds and staffs one (1) staff member to five (5) patient.
- Adult Intensive Care Unit has 14 beds and staffs 1:5 ratio.
- Adult Intermediate Unit has 20 beds and staffs 1:6 ratio.
- Senior Unit has 16 beds and staffs 1:4 ratio.

During an interview on 03/12/18 at 11:00 a.m. in the Conference Room, the CNO (#1) stated he/she had been at the facility a little over two (2) weeks. He/she explained that the facility has 24 hours a day nursing team coverage. He/she explained that the nursing teams consist of RNs, Licensed Practical Nurses (LPNs), and MHTs. The CNO said that the facility utilizes the Crisis Prevention Intervention training when teaching staff how to perform appropriate holds and to de-escalate patients. The CNO confirmed that the facility has a contract with AMN Healthcare, Incorporated to provide agency nursing staff as needed, but that the facility was not currently using any agency staff. The CNO explained that two (2) weeks ago he/she met with staff and discussed the 15 minutes round sheets. The CNO said that he/she informed staff that Observation sheets were to be completed in real time and that staff could not leave the form blank and go back and document later or document early as this is falsifying documentation.

Tours of the facility were conducted as follows:

--On 03/12/18 at 11:45 a.m., a tour of the Adolescent Unit was conducted with the CEO (#13). There was a total of 20 beds in 10 semi-private rooms. There were 19 patients on the unit at the time of the tour with five (5) staff members working the unit. There were three (3) RNs and two (2) MHTs. The two (2) MHTs were actively performing every 15 minutes checks on the 19 patients. No patients were on more intense monitoring or safety precautions at the time of the tour.

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Review of staffing for this unit from 01/20/18 through 02/04/18 (total of 32 shifts) revealed the unit was understaffed 10 of 32 shifts or 31 percent per facility's "practice" which required a 1:5 ratio for this unit. The staffing shortage was as follows:

- 01/21/18 short one (1) staff member on both shifts.
- 01/22/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/23/18 7:00 a.m. to 7:00 p.m. two (2) staff member needed.
- 01/28/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/29/18 short one (1) staff member on both shifts.
- 01/31/18 short one (1) staff member on both shifts.
- 02/04/18 7:00 a.m. to 7:00 p.m. two (2) staff member needed.

--On 03/12/18 at 11:45 a.m. a tour of the Adult Intensive Care Unit was conducted with the Nursing Supervisor (#14) on duty. It was observed that the unit had a capacity of 20 beds and staffing was to be 1:5 ratio. The census was 12 patients and the unit was staffed with a RN/Charge Nurse (#7), a LPN (#4), and a MHT (#17).

One (1) of the 12 patients was in the process of being discharged by LPN #4; who then, at 11:50 a.m. escorted the patient off the unit for discharge. The RN and MHT remained on the unit to manage the remaining 11 patients. At approximately 11:55 a.m., the MHT notified the RN/Charge Nurse that he/she was escorting seven (7) patients for a smoke break outside. The RN remained on the unit to monitor the remaining four (4) patients who required 15 minutes observations, provide routine nursing care and the necessary clinical documentation. The MHT returned to the unit at noon with the seven (7) patients.

Interviews were conducted at the Nurses Station on the unit at 11:45 a.m. on 03/12/18 with employees #7 and #4. Interviewee #7 stated it was the facility's practice that nurses were typically assigned to varying units during their monthly schedule to meet patient care demands and that staffing was adjusted each shift by the Nursing Supervisor on duty. Employee #4 stated the LPN role includes all RN responsibilities except for performing Initial Assessments.

A review of the Patient Safety Precautions Records for 03/12/18, revealed that six (6) of 11 patients assigned to the MHT lacked documentation of every 15 minutes checks from 7:15 a.m. to 12:45 p.m. These findings were brought to the attention of the Nursing Supervisor (#14) on duty, who in turn reported it to the CNO.

Review of staffing for this unit from 01/20/18 through 02/04/18 (total of 32 shifts) revealed 22 of 32 shifts or 69 percent were not in compliance with the facilities practice of a 5:1 ratio on the unit, as stated by the CEO (#13), CNO (#1) and Nursing Supervisor (#14). The staffing shortage was as follows:

- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/22/18 short one (1) staff member on both shifts.
- 01/23/18 short one (1) staff member on both shifts.
- 01/24/18 short one (1) staff member on both shifts.
- 01/25/18 short one (1) staff member on both shifts.
- 01/26/18 short one (1) staff member on both shifts.
- 01/27/18 short one (1) staff member on both shifts.
- 01/28/18 short one (1) staff member on both shifts.
- 01/29/18 short one (1) staff member on both shifts.
- 01/30/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/31/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/02/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/03/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/04/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.

--On 03/12/18 at 11:45 a.m. a tour of the Adult Intermediate Unit was conducted with the Manager of Intake (#16), this unit has 20 beds with a census of 15 patients. The unit was calm and quiet. As stated by the CEO and CNO this unit required a staff to patient ratio of 1:6. There were 5 patients upstairs across from the nursing station with one (1) RN, one (1) MHT, and one (1) LPN in the medication room. There were 10 patients downstairs in the exercise room with the fitness coach and one (1) MHT who comes down every 15 minutes to check on the patients. The Patient Safety Precautions Records were all up to date and on the correct time frame.

The staffing review of the adult intermediate unit from 1/20/18 through 02/04/18 (total of 32 shifts) revealed that

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11 of 32 shifts or 34 percent of the shifts were understaffed. As stated by the CEO (#13) and CNO (#1) of the facility this unit required a staff to patient ratio of one (1) to six (6). Staffing deficiencies were noted on the following dates:

- 01/20/18 7:00 a.m. to 7:00 p.m. one (1) staff members needed.
- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff members needed.
- 01/24/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/24/18 7:00 p.m. to 7:00 a.m. one (1) staff members needed.
- 01/25/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/25/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
- 01/26/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/27/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 02/04/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/04/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.

---On 03/12/18 at 11:45 a.m. a tour of the Senior Unit was conducted with the CNO (#1). The unit had 16 beds with a census of nine (9) patients. There was one (1) RN and 3 MHTs. One (1) MHT was in his/her second day of orientation to the unit. There were eight (8) patients in a group room with a leader and 1 (one) MHT monitoring the patients and one (1) patient was meeting with the Registered Dietitian. The Patient Safety Precautions Records were completed in accordance with policy, none were either "pre" nor "post" marked. The unit was clean, calm, and orderly.

Review of the staffing for nursing for the Senior Unit from 01/20/18 to 02/04/18 revealed that 20 of 32 shifts or 63 percent of shifts were understaffed per facility "practice". Staffing deficiencies were noted on the following dates:

- 01/20/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/20/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/23/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/23/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/24/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/25/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/25/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/26/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/26/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
- 01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/28/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/28/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/29/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/29/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/30/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/30/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 02/03/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/04/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.

During the tour, all units were found to be staffed per facility policy. All units were clean and tidy, chairs were found to be light weight and easily movable. All beds were found to be made of heavy materials. All door hardware and bathroom fixtures were anti-ligature. There were no shower curtains or rods. All doors to patient rooms were locked. Doors to bathrooms and patient rooms were slanted to diminish ligature potential. All doors exiting the units were locked. Patient rights were posted in the day rooms.

Review of facility policies and procedures included but was not limited to the following:

1. Patient Rights, effective date of 01/17, with a reviewed date of 01/18, revealed that the policy is to ensure that all patients receive a copy of the Patient's Bill of Rights and Responsibilities form, as well as an oral explanation of those rights, both in their primary language and in simple non-technical terms.

The procedure is as follows:

- Prior to admission, each individual shall be provided with a copy of the Patient's Bill of Rights form and a verbal explanation to those rights in their primary language in simple non-technical language. The minor's parent, managing conservator or legal guardian will be given the patient's Bill of Rights form. The information is

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provided in a manner tailored to the patient's age, language, and ability to understand.

---A copy of the Patient's Bill of Rights form shall be displayed prominently at all times in each of the following locations: waiting room and lobby areas, cafeteria, dayrooms, recreational rooms, and any other areas frequented by persons receiving services. Copies shall also be available at these locations to anyone requesting a copy.

The summary of Patient Rights and Responsibilities lists the following:

---To provide care and treatment that is respectful, recognizes a person's dignity, cultural value and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment.

---To be free of abuse and neglect.

---Care delivered by the health care entity in accordance with the needs of the patient.

---To receive care in a safe setting.

2. Assessment/Reassessment by RN, effective Date of 01/17, with a reviewed date of 01/18, revealed the following procedure:

---The RN completes the RN Assessment within 8 hours.

---Formulates a nursing care plan including a discharge plan.

---Reassesses the patient every shift and whenever the patient's bio-psychosocial status or precautions level changes; within 72 hours of admission; every thirty minutes if a patient is in restraint or seclusion, and if a patient is identified to have a physical complaint.

3. Staff Assignments, effective date of 01/17, no revision or review date noted, revealed the purpose is to ensure safe practice and quality patient care.

---All clinical staff shall be competent to fulfill their assigned responsibilities.

---Job descriptions shall be written to clarify role, responsibilities and qualifications necessary to carry out the role.

---All newly employed staff shall complete orientation before assuming responsibilities for patient care.

Assignment of patient care staff shall include the consideration of:

a) Patient condition and care requirements.

b) Patient acuity and stability.

c) Complexity of patient assessment.

d) Degree of supervision required by staff.

e) Infection control and safety issues.

f) Environment in which the nursing care is provided.

The charge nurse will complete staff assignments.

Review of the Nurse Staffing Plan revealed that care is provided by a team of RNs, LPNs, and MHTs.

Employees will have documented competence and orientation specific to the care of the patient population being served. The core staffing level is projected based upon the following critical factors:

---patient characteristics and number of patients cared for including admissions, discharges and transfers.

---intensity of patient care being provided and the variability of patient care across the unit.

---scope of services provided, architecture and geography of the unit.

---characteristics of the staff including: consistency and tenure, preparation and experience, the number and competencies of clinical and non-clinical support staff the nurse must collaborate or supervise.

The CNO meets with Charge Nurses from each patient care area daily (Monday-Friday) to evaluate staffing needs and make appropriate adjustments in the number and blend of nursing care personnel to ensure delivery of optimal patient care using the daily staffing plan.

The core staffing plan will be evaluated and recalculated at least annually or as necessary. This evaluation will utilize one of each of the following three types of outcomes:

---Patient outcomes that are nursing sensitive such as; patient falls, adverse drug events, injuries to patients, skin breakdown, pneumonia, infection rates, cardiac arrest, length of stay or readmissions.

---Operational Outcomes such as work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on call agency use, or overtime rates.

---validated patient complaints related to staffing levels.

Nurses that have concerns related to staffing shall report their concerns timely according to the hospital's human resources policies. There shall be no retaliation for reporting concerns. The committee responsible for developing, monitoring and evaluating the plan to address these concerns. This feedback will be reported back to the nurses who raise the concerns.

4. Observation levels, effective date of 01/17, with a reviewed date of 01/18, revealed it is the policy of the facility

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to provide a safe and secure environment for patients during their hospitalization. Special precaution procedures can be initiated by physician or nursing staff when a patient may be an increased risk for harm to self, others or property, or for those patients who need an increased level of observation and precaution for other reasons. The nurse or physician should determine the level of risk associated with each new admission and throughout their hospitalization. A rounds sheet must designate special observations on the patient. Precaution Levels are as follows:

- One to One guidelines maintain that the patient is monitored by 1:1 staff ratio at all times, within reaching distance at all times. Patient Rounds Sheet (PRS) which reflects the patient's location and observed behaviors every fifteen minutes is maintained at all times.
- Constant Observation (Line of Sight) guidelines maintain the patient in visual range of assigned staff at all times. PRS is maintained at all times.
- Close Observation guidelines maintain PRS is maintained at all times.

5. Documentation Observation Sheet Guidelines, effective date of 01/17, with a revision date of 02/18, revealed the following information shall be documented every fifteen (15) minutes as appropriate

- Patient's exact location
- Pertinent descriptions of patient's current condition, behavior or activity
- Significant patient responses to the care provided by the staff
- Time that precautions were implemented and discontinued

The staff member assigned to do the fifteen (15) minute checks and/or 1:1 on a patient shall be responsible for documenting on the Documented Observation Sheet. If the patient is off the unit or in a group activity, documentation on the Documented Observation Sheet shall be performed by the staff member who is with the patient.

6. Grievances and the Patient Advocate, effective date of 01/2017, with no revision or review date, revealed the facility will provide an effective mechanism for handling patient, family, guardian, patient's representative and/or patient's surrogate grievances as an important part of providing quality care and service to our patients.

The procedure is as follows:

- The patient and others are informed of the patient's rights and responsibilities upon admission, and the process by which they can voice any concerns related to their rights and/or treatment. This information includes the name of the patient advocate, and the method of access to the patient advocate. The patient advocate's name and phone number are also posted in the lobby and on the unit.
- When a patient voices a complaint, the patient may be encouraged to discuss the complaint with their physician or unit nursing staff.
- If the issue cannot be resolved at this level (or if the patient wishes to contact the patient advocate directly), the patient will have access to the Patient Advocate/designee to facilitate resolution of the grievance. An issue becomes a grievance if it involves an allegation of abuse or neglect, a patient's right violation, or it can't be resolved prior to discharge. A grievance must be filled within a reasonable timeframe, and no later than sixty (60) days following the occurrence. Receive care in a safe environment and be free from all forms of abuse and harassment.
- Each patient and all making a complaint will receive a response from the facility staff that addresses the complaint in a timely manner (with-in one week). The response should be written on the complaint form and signed by the patient. If the patient is no longer at the facility the response should have a response letter sent to the last known address. The written response is to be provided with-in thirty (30) days of the filed grievance.
- Complaints received in written form should be forwarded directly to the chief executive officer (CEO) or designee who should delegate investigation to the appropriate staff members.
- Any written responses to patients and /or family members should be reviewed by the CEO or designee prior to being sent.
- The patient advocate will investigate all complaints received from patients and others, as appropriate responds to patient/family grievances promptly.

7. Medical Emergencies, effective date of 01/2017, with no revision or review date, revealed that the facility will provide basic first aid, basic life support, and notification to emergency services in the event of an unexpected illness or injury in a patient, visitor, staff member, or any other person to the extent that the equipment and expertise will allow the facility at the time of the event.

The procedure is as follows:

- The staff person witnessing or receiving an initial report of an illness, accident, or injury requiring emergency response will activate the emergency by calling a "Code Blue" over the paging system.
- All patients will be examined on the inpatient unit, if possible.

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- The nursing supervisor/designee will respond to the site with the emergency cart.
- Other individuals may respond as they are available which may include, but not be limited to: any physician in the building and all available nurses.
- Nursing and/or medical staff, will determine the nature of the medical emergency and, if a patient of the hospital, contact the internal medicine group, the attending physician and/or the on-call physician for medical orders.
- If the life-threatening emergency exists, basic life support measures will be initiated and a 911 call placed to activate the Emergency Medical System.
- Available staff not engaged in the medical emergency will make copies of appropriate portions of the medical record to send to the hospital with any patient requiring transport to an Emergency department.
- A patient status report will be called to the Emergency department of the receiving hospital. Once the medical emergency has been addressed, a Memorandum of Transfer will be prepared and forwarded at the first available opportunity.
- Employees requiring medical care will be subsequently referred to the Director of Human Resources, if possible, to review the need for workman's compensation services.
- Other individuals requiring non-emergent medical care will receive a recommendation to contact their primary care provider.
- An incident report will be completed documenting details of any event.

During an interview on 03/12/18 at 12:30 p.m. in the Conference Room, the DRMPI (#2) explained that patients receive a copy of their patient rights upon admission and that patient rights is posted on every unit in the Day Room. The DRMPI said that patients and/or their representative sign the consent for treatment, receive Advanced Directive information as requested, and are informed of how to file a grievance. The DRMPI confirmed that staff receive CPI training upon hire and annually. In addition, he/she explained that Quality Data reports are reviewed and tracked for any trends. In addition, he/she explained that a new system was being presented to the Corporate Office later this month and that the new system provided a severity level to all occurrences. The DRMPI confirmed that there were no complaints lodged by any of the 10 sampled patients as listed above (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10).

During a second tour of the facility with the CNO on 03/12/18 at 1:10 p.m., the CNO (#1) explained that the facility had already identified that the chairs on the units were light and was in the process of getting heavier chairs. In addition, the CNO explained that the facility was also going to be changing out the hand sanitizers because the hand sanitizers at present are metal and the facility is going to safety hand sanitizers.

During an interview on 03/12/18 at 4:00 p.m. in the Conference Room MHT #9 stated he/she has been at this facility since 01/09/17 when the facility opened. He/she explained there had not been a lot of staff turnover. MHT #9 said he/she works on the adolescent unit and that rounding is done every 15 minutes, but sometimes sooner to keep the patients off guard. Staff #9 said that he/she was trained to do rounding this way. MHT #9 confirmed that he/she was on duty the day that the patient hung him/her self, and that the Nursing Supervisor (#3) went over to the unit where this patient was located. MHT #9 stated he/she thought the ratio on the unit was 1:7. The MHT said that today there were 19 patients on the unit with 3 RNs and 2 MHTs. MHT #9 said the RNs do help monitor patients. He/she said today "I have 11 patients and the other MHT had 8 patients" but the nurses help with monitoring. MHT #9 confirmed that he/she is aware to contact the Nursing Supervisor with any staffing concerns and of the Human Resources (HR) policy on contacting HR regarding staffing issues.

During an interview with LPN (#4) on 03/12/18 at 4:35 p.m. in the Conference Room, the LPN said he/she has been a nurse since 1994 and has been at this facility for five (5) months. The nurse said staffing could be better. He/she stated, I came in during a hiring wave (lot of new employees). The LPN explained that there has been a change in management recently. The LPN stated the units are normally staffed on a 1:5 ratio. The LPN said that MHTs and nurses monitor patients. The LPN explained that the facility had recently started adding a second person to help monitor patients in groups. The LPN confirmed that he/she was the staff member that had been hit in the face with a chair. The nurse explained that acuity on that unit had been high that night and that staffing could have been better. The LPN said that he/she thinks the new CNO walked into a hell storm, and that he/she (LPN) feels that the staffing is better since the new CNO has arrived.

During an interview with (b)(6) (b)(7)(c) (#10) on 03/13/18 at 10:30 a.m. in the Conference Room, the Director explained that he/she had been at the facility for five (5) months. He/she explained that prior to the hanging incident he/she had adjusted all patient bathroom doors so that they close for privacy but do not latch. He/she stated the facility had two (2) bids out to get all patient bathroom doors lowered.

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The (b)(6) (b)(7)c explained that even though the bathroom doors are slanted the facility decided to lower the doors to prevent any items from being able to catch in the corners next to the hinges.

During an interview on 03/13/18 at 12:00 p.m. in the Conference Room (b)(6) (b)(7)c #3) stated he/she started work at this facility when the facility first opened. The Supervisor confirmed that he/she was the supervisor on duty at the time the patient hung himself/herself (patient #1). The Supervisor explained that the Supervisor's role is to cover the entire house. He/she explained that the patient hung him/her self on a Saturday after visiting hours. The Supervisor went on to say that on that day (01/20/18) there were a couple of psychiatric codes with patients on the acute unit. The Supervisor explained that he/she had just left the acute unit and had gone to his/her office at the end of the hall on the acute unit when he/she heard the code blue page to respond to the adult intermediate unit. The Supervisor said that when he/she arrived a staff member was performing cardiopulmonary resuscitation on the patient. The Supervisor said that he/she ran and called 911, returned to the room and began to bag the patient as the crash cart had arrived while he/she had gone to call 911. The Supervisor said that EMS arrived and hooked the patient up to their (EMS) monitor and that the EMS reported that the patient's heart rate was in the high 100s (normal 60-100). The Supervisor confirmed that the unit had been staffed with two (2) RNs, one (1) MHT at the time, and one (1) Security Officer who was monitoring a patient 1:1. The Supervisor confirmed that Supervisors adjust staffing on the weekends according to the census on the units and patients' acuity, and for any special observation status that is ordered.

Eleven out of eleven personnel files revealed that there was current crisis prevention intervention (CPI) training per facility policy. The facility utilized the following nursing positions for patient care:

1. Nursing Supervisor Position Summary: The role is responsible for ensuring delivery of patient care consistent with the established standards of care of mental health practice and hospital policy, goals and objectives.

Qualifications: Graduate of an accredited school of nursing required or equivalent combination of education of education and experience in psychiatric nursing experience management. An experience level of three (3) years' experience in a psychiatric health-care facility. Additional requirements include a CPR certification and successful completion of the CPI training within 90 days of employment.

Standards of Performance: Include, leadership, personnel management, treatment planning, teaching, milieu (personal environment) management, clinical intervention, clinical assessment, performance management of employees as assigned and specific standards of care for adult patients ages 1 (b)(6) (b)(7)c years and older, care of chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

2. Staff Nurse (RN) Position Summary: A RN who prescribes, coordinates, and evaluates patient care by working together with health care team according to nursing process and standards of care practices.

Qualifications: Graduate of an accredited school of nursing required or equivalent combination of education and experience in psychiatric nursing; three (3) years' experience in a psychiatric health-care facility is preferred.

Additional requirements include a CPR certification and successful completion of CPI within 90 days of employment and prior to assisting in restraining patients.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations and risk management.

Specific standards of care for children ages (b)(6) (b)(7)c adults age (b)(6) (b)(7)c psychiatric patients age (b)(6) (b)(7)c older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

3. Staff Nurse (LPN) Position Summary: This position is a LPN who assists in providing nursing care with a health care team according to nursing process and standards of care practices.

Qualifications: Graduate of an accredited LPN program is required. Three (3) years' experience in a psychiatric health-care facility is preferred. Additional requirements include a CPR certification and successful completion of CPI within 90 days of employment and prior to assistance in restraining procedures.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations and risk management. Specific standards of care for children ages (b)(6) (b)(7)c psychiatric patients age (b)(6) (b)(7)c older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the

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facility as necessary for patient care.

4. MHT Position Summary: Functions as an active part of the treatment team, providing continuous patient care, supervision, interaction and role modeling to patients ranging in age from pre-school through geriatrics depending on which units worked. The MHT works under the direction of an RN.

Qualifications: A CPR certification and successful completion of CPI within 90 days of employment and prior to assistance in restraining procedures.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations. Specific standards of care for children ages (b)(6) (b)(7)c, adults ages (b)(6) (b)(7)c, geriatric patients ages (b)(6) (b)(7)c, older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

Review of the facility's staffing from 03/04/18 through 03/10/18 for a total of 14 shifts revealed the following:

- Adolescent unit was staffed appropriately per facility policy for census and acuity.
- Adult Intensive Care Unit was staffed appropriately per facility policy for census and acuity.
- Adult Intermediate Unit staffed appropriately per facility policy for census and acuity.
- Senior Unit staffed appropriately per facility policy for census and acuity.

On 03/13/18 at 4:30 p.m. the facility's corrective actions were reviewed. The corrective actions that were put in place prior to the survey included the following:

1. Attempts to obtain a copy of the acute hospital's medical record were refused due to the facility's inability to get a release of information from the family.
2. Attempts to get a copy of the Georgia Bureau of Investigation's autopsy report were still in progress as the report was still pending.
3. The CEO hired a new CNO on 02/14/18, the new CNO started a little over two (2) weeks ago.
4. The CEO hired a new Director of RM/PI.
5. Staff that were found to not be following facility policy were terminated.
6. The facility has hired three (3) new RNs and seven (7) new MHTs. The CNO confirmed that he/she is still interviewing and had two (2) RNs interviews today.
7. Brought personal alarms that attach to employee name badges. These alarms can be used to signal for assistance by emitting a shrill alarm when activated. The CEO explained this will prevent staff from having to leave a patient to get help. The CNO stated 80 percent of employees have the alarms and another shipment is scheduled to arrive 3/14/18 to ensure that 100 percent of staff have the alarms.
8. In-services provided by the CNO at the Town Hall Meeting for staff on 02/27/18, 02/28/18, and 03/01/18 at various times revealed sign-in sheets of attendees. These in-services covered patient safety, every 15 minutes observations, importance of charting observations in real time (pre-or post charting was explained by the CNO to be falsification), Triggers to Look For, and Alternative Crisis Management.
9. Added a column for staff to document hand-off to another staff member on the observation flow sheets.
10. Nursing Supervisor check point for shift assessments/rounds.
11. Overview of orientation, orientation to include patient safety, staff safety, rounding.
12. Developed an Infection Control/Educator position that has been filled.
13. A QA/PI determined overhead page was to be turned up.
14. New policy to keep all patient rooms locked during the day (rooms had been kept unlocked so patients could go to their bathroom) and one (1) hall bathroom is now utilized.

Based on review of the facility's Quality Data, medical records, video recordings, staff interviews, tours, observations, staffing, policies and procedures, personnel files, job descriptions, and the facility's corrective action plan, it was determined that an Immediate Jeopardy occurred from 01/20/18 through 02/04/18. No deficiencies were cited due to the facility's corrective actions which were implemented prior to the survey.

Findings Text:

Category: Nursing Services

Subcategory: Insufficient Staff / Inadequate Staffing

Seriousness: Critical

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Findings: Substantiated: No deficiencies related to the alleg are cited

Details: The complainant alleged that the facility failed to ensure that sufficient staff was provided and available to provide safe and effective patient care. Specifically, the complainant alleged that the facility lacked sufficient staff to maintain/provide physician-ordered continuous monitoring of its patients and as a result, staff have been injured and a patient committed suicide.

The facility's Quality Data was reviewed from January 1, 2018 through March 12, 2018. This data included: patients found with contraband, patient on patient touching or kissing, a drawstring in pants, damage to property, patient on patient hitting with minor to no injuries, self-injurious behavior, patients inflicting injuries to staff, and one (1) hanging. The Quality Data and/or the sampled medical records revealed:

--Patient #1 was admitted on 01/11/18 with a diagnosis of Major Depression Disorder (MDD) and Suicidal Ideations (SI). The patient was admitted on a 1013 (Georgia's Law that allows a patient to be held involuntarily when the patient presents a danger to self or others). The physician's admission orders revealed the patient was placed on every 15 minutes monitoring and daily suicide risks assessments. Physician orders revealed an order on 01/19/18 for the patient to be moved to a room across from the nurses' station (this order was never carried out), and on 01/20/18 the physician wrote an order for the patient to be allowed to go to his/her room (#208) for 30 minutes.

Nursing documentation revealed the patient denied suicidal thoughts on 01/15/18, 01/16/18, and 01/17/18, passively endorsed suicidal thoughts on 01/18/18, and denied suicidal thoughts on 01/19/18 and 01/20/18. The Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from the time of admission until the time the patient was found hanging from the his/her bathroom door at 5:15 p.m. on 01/20/18. Review of the Code Blue sheet revealed the patient was found hanging from the bathroom door by a sweat shirt at 5:15 p.m. during the every 15 minutes rounds. The Code Blue sheet revealed cardiopulmonary resuscitation (CPR - chest compressions and assisted breathing) was initiated at 5:16 p.m. The Code Blue sheet indicated that 911 was called at 5:17 p.m. and that an intravenous (inserted into a vein) line was placed at 5:22 p.m. and a bag of normal saline (fluid) was hung. This form revealed the patient had no pulse and no respirations when found. The form indicated that when the ambulance attendants removed the patient from the facility the patient's heart rate was in the 160s (normal 60-100). Nurses' notes and a note from the Chief Executive Officer (CEO #13) revealed the physician and the patient's family were notified.

The facility's video recording was reviewed with the Director of Risk Management/Performance Improvement (DRMPI #2) on 01/13/18 at 1:00 p.m. in the CEO's office. The video record was dated 01/20/18 and time stamped 4:00 p.m. The recording showed the Adult Intermediate hall from the end of the hallway facing down toward the Nurses' Station and Day Room, nurse (registered nurse RN #11) is seen in the hallway. Doors to room number 202 and 203 are observed to be open. At 4:04 p.m. the patient is seen exiting the day room heading toward his/her room (208), the patient passes RN #11 and they briefly speak. The patient is seen entering his/her room. There is no monitoring of the patient from 4:04 p.m. until 5:12 p.m. when the Mental Health Technician (MHT #12) enters the patient's room. MHT #12 is observed coming out of the room and then numerous staff enter the room. At 5:14 p.m. the Nurse Supervisor (#3) is seen running down the hall to the patient's room and then running to call 911. At 5:16 p.m. a staff member arrives with the crash cart. At 5:18 a physician is seen entering the patient's room and leaving within 30 seconds. At 5:22 p.m. the police arrive. At 5:24 p.m. the Emergency Medical Service (EMS) team arrive. At 5:36 p.m. EMS leave with the patient on a stretcher with an Automatic Chest Compression Device (delivers chest compressions) attached to the patient. In addition, the EMS are observed bagging (rescue respirations) the patient.

The CEO (#13) entered his/her office on 01/13/18 at 1:30 p.m. while surveyors were watching the above video. The CEO stated and confirmed that the patient had not been monitored and stated that he/she had watched the video right after the occurrence and found that the MHT (#12) assigned to monitor the patient had been sitting at the nurses' desk for over an hour and had not monitored the patient. The CEO explained that the MHT (#12) and RN (#11) had been immediately terminated for not following facility policy.

--Patient #2 was admitted on 02/01/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/04/18, documentation revealed the patient was throwing chairs in the day room and that a staff member (#4) was injured. An order was received to place the patient in a hold and move the patient to the seclusion room for up to two (2) hours. Documentation revealed the patient was placed in a five (5) minute hold and then placed in seclusion for 31 minutes. Documentation revealed the patient was monitored every 15 minutes while in seclusion, received an assessment after being removed from seclusion, and that a face to face was completed within one (1) hour after the patient was removed from seclusion. In

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addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #3 was admitted on 01/30/18 with a diagnosis of Bipolar Disorder (mood swings from extreme high to extreme low) and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/04/18, documentation revealed the patient was throwing chairs in the day room and that a staff member (#4) was injured. An order was received to place the patient in a hold. Documentation revealed the patient was placed in the hold and de-escalated per physician orders and facility policy. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/06/18.

--Patient #4 was admitted on 12/20/17 with a diagnosis of unspecified psychosis (loss of touch with reality), aggression, and inappropriate sexual behavior. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/02/18, documentation revealed the patient was agitated, being sexually aggressive toward peers, and hit a staff member. Documentation revealed an order was received to give the patient Haldol for sedation and to place the patient in seclusion for up to 30 minutes. Nurses' notes revealed the physician's orders were carried out and that the patient was monitored while in seclusion. In addition, the Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from admission to discharge on 01/31/18.

----Patient #5 was admitted on 01/13/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/19/18, documentation revealed the patient was found to have scratched his/her thighs with a plastic spoon that the patient reported finding. Documentation revealed the physician ordered the patient to be "blocked from room for 24 hours" (not allowed in his/her room) due to self-injurious behavior. Documentation revealed the patient's belongings were searched during this time. In addition, the Patient Safety Precautions Records revealed the patient was monitored every 15 minutes from admission to discharge on 01/22/18.

--Patient #6 was admitted on 01/23/18 with a diagnosis of Attempted Suicide and Overdose. Physician orders revealed the patient was placed on routine 15 minutes observation. On 01/29/18, documentation revealed the patient hit a wall. An order was received to place the patient on line of sight (kept within sight at all times) for 24 hours. Documentation revealed the patient was monitored as ordered. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #7 was admitted on 01/24/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 02/02/18, documentation revealed the patient hit a peer. Physician orders and monitoring sheets revealed the patient was placed on close observation. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #8 was admitted on 02/01/18 with a diagnosis of MDD and SI. Physician orders revealed the patient was placed on routine 15 minutes observation. On 03/04/18 documentation revealed the patient knocked a printer off a desk and that the printer hit a staff member in the back. Physician orders and the medication administration record revealed the patient was medicated with Haldol (medication used to calm patients) as ordered. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #9 was admitted on 01/02/18 with a diagnosis of Bipolar. Physician orders revealed the patient was placed on routine 15 minutes observation. Documentation revealed that the patient was found to have a drawstring in his/her pants and that the drawstring was removed for safety. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

--Patient #10 was admitted on 12/28/17 with a diagnosis of Bipolar. Physician orders revealed the patient was placed on routine 15 minutes observation. Documentation revealed the patient was observed salivating and having difficulty breathing, staff performed "CPR" (Heimlich maneuver) and the patient coughed up a yellow magic marker cap. Documentation revealed the patient and his/her room was then searched for contraband. In addition, the Patient Safety Precautions Records revealed this patient was monitored every 15 minutes from admission to discharge on 02/12/18.

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During the entrance on 03/12/18 at 10:30 a.m. in the Conference Room, the CEO (#13) explained that he/she had been with the facility since 01/08/18. The Chief Nursing Officer (CNO #1) explained that he/she had been with the facility for two (2) weeks, and the DRMPI (#2) stated he/she had been with the facility for about one (1) month. The CEO and CNO explained that nursing staff work 12-hour shifts, the shifts are from 7:00 a.m. to 7:00 p.m. (day shift) and 7:00 p.m. to 7:00 a.m. (night shift). In addition, the CEO and CNO explained that the facility has four (4) units which include the following:

- Adolescent Unit (12 to 17 years old or 18 years old and still in high school) which has 20 beds and staffs one (1) staff member to five (5) patient.
- Adult Intensive Care Unit has 14 beds and staffs 1:5 ratio.
- Adult Intermediate Unit has 20 beds and staffs 1:6 ratio.
- Senior Unit has 16 beds and staffs 1:4 ratio.

During an interview on 03/12/18 at 11:00 a.m. in the Conference Room, the CNO (#1) stated he/she had been at the facility a little over two (2) weeks. He/she explained that the facility has 24 hours a day nursing team coverage. He/she explained that the nursing teams consist of RNs, Licensed Practical Nurses (LPNs), and MHTs. The CNO said that the facility utilizes the Crisis Prevention Intervention training when teaching staff how to perform appropriate holds and to de-escalate patients. The CNO confirmed that the facility has a contract with AMN Healthcare, Incorporated to provide agency nursing staff as needed, but that the facility was not currently using any agency staff. The CNO explained that two (2) weeks ago he/she met with staff and discussed the 15 minutes round sheets. The CNO said that he/she informed staff that Observation sheets were to be completed in real time and that staff could not leave the form blank and go back and document later or document early as this is falsifying documentation.

Tours of the facility were conducted as follows:

--On 03/12/18 at 11:45 a.m., a tour of the Adolescent Unit was conducted with the CEO (#13). There was a total of 20 beds in 10 semi-private rooms. There were 19 patients on the unit at the time of the tour with five (5) staff members working the unit. There were three (3) RNs and two (2) MHTs. The two (2) MHTs were actively performing every 15 minutes checks on the 19 patients. No patients were on more intense monitoring or safety precautions at the time of the tour.

Review of staffing for this unit from 01/20/18 through 02/04/18 (total of 32 shifts) revealed the unit was understaffed 10 of 32 shifts or 31 percent per facility's "practice" which required a 1:5 ratio for this unit. The staffing shortage was as follows:

- 01/21/18 short one (1) staff member on both shifts.
- 01/22/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/23/18 7:00 a.m. to 7:00 p.m. two (2) staff member needed.
- 01/28/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/29/18 short one (1) staff member on both shifts.
- 01/31/18 short one (1) staff member on both shifts.
- 02/04/18 7:00 a.m. to 7:00 p.m. two (2) staff member needed.

--On 03/12/18 at 11:45 a.m. a tour of the Adult Intensive Care Unit was conducted with the Nursing Supervisor (#14) on duty. It was observed that the unit had a capacity of 20 beds and staffing was to be 1:5 ratio. The census was 12 patients and the unit was staffed with a RN/Charge Nurse (#7), a LPN (#4), and a MHT (#17).

One (1) of the 12 patients was in the process of being discharged by LPN #4; who then, at 11:50 a.m. escorted the patient off the unit for discharge. The RN and MHT remained on the unit to manage the remaining 11 patients. At approximately 11:55 a.m., the MHT notified the RN/Charge Nurse that he/she was escorting seven (7) patients for a smoke break outside. The RN remained on the unit to monitor the remaining four (4) patients who required 15 minutes observations, provide routine nursing care and the necessary clinical documentation. The MHT returned to the unit at noon with the seven (7) patients.

Interviews were conducted at the Nurses Station on the unit at 11:45 a.m. on 03/12/18 with employees #7 and #4. Interviewee #7 stated it was the facility's practice that nurses were typically assigned to varying units during their monthly schedule to meet patient care demands and that staffing was adjusted each shift by the Nursing Supervisor on duty. Employee #4 stated the LPN role includes all RN responsibilities except for performing Initial Assessments.

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A review of the Patient Safety Precautions Records for 03/12/18, revealed that six (6) of 11 patients assigned to the MHT lacked documentation of every 15 minutes checks from 7:15 a.m. to 12:45 p.m. These findings were brought to the attention of the Nursing Supervisor (#14) on duty, who in turn reported it to the CNO.

Review of staffing for this unit from 01/20/18 through 02/04/18 (total of 32 shifts) revealed 22 of 32 shifts or 69 percent were not in compliance with the facilities practice of a 5:1 ratio on the unit, as stated by the CEO (#13), CNO (#1) and Nursing Supervisor (#14). The staffing shortage was as follows:

- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/22/18 short one (1) staff member on both shifts.
- 01/23/18 short one (1) staff member on both shifts.
- 01/24/18 short one (1) staff member on both shifts.
- 01/25/18 short one (1) staff member on both shifts.
- 01/26/18 short one (1) staff member on both shifts.
- 01/27/18 short one (1) staff member on both shifts.
- 01/28/18 short one (1) staff member on both shifts.
- 01/29/18 short one (1) staff member on both shifts.
- 01/30/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/31/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/02/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/03/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/04/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.

--On 03/12/18 at 11:45 a.m. a tour of the Adult Intermediate Unit was conducted with the Manager of Intake (#16), this unit has 20 beds with a census of 15 patients. The unit was calm and quiet. As stated by the CEO and CNO this unit required a staff to patient ratio of 1:6. There were 5 patients upstairs across from the nursing station with one (1) RN, one (1) MHT, and one (1) LPN in the medication room. There were 10 patients downstairs in the exercise room with the fitness coach and one (1) MHT who comes down every 15 minutes to check on the patients. The Patient Safety Precautions Records were all up to date and on the correct time frame.

The staffing review of the adult intermediate unit from 1/20/18 through 02/04/18 (total of 32 shifts) revealed that 11 of 32 shifts or 34 percent of the shifts were understaffed. As stated by the CEO (#13) and CNO (#1) of the facility this unit required a staff to patient ratio of one (1) to six (6). Staffing deficiencies were noted on the following dates:

- 01/20/18 7:00 a.m. to 7:00 p.m. one (1) staff members needed.
- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff members needed.
- 01/24/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/24/18 7:00 p.m. to 7:00 a.m. one (1) staff members needed.
- 01/25/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
- 01/25/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
- 01/26/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/27/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 02/04/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 02/04/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.

--On 03/12/18 at 11:45 a.m. a tour of the Senior Unit was conducted with the CNO (#1). The unit had 16 beds with a census of nine (9) patients. There was one (1) RN and 3 MHTs. One (1) MHT was in his/her second day of orientation to the unit. There were eight (8) patients in a group room with a leader and 1 (one) MHT monitoring the patients and one (1) patient was meeting with the Registered Dietitian. The Patient Safety Precautions Records were completed in accordance with policy, none were either "pre" nor "post" marked. The unit was clean, calm, and orderly.

Review of the staffing for nursing for the Senior Unit from 01/20/18 to 02/04/18 revealed that 20 of 32 shifts or 63 percent of shifts were understaffed per facility "practice". Staffing deficiencies were noted on the following dates:

- 01/20/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/20/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
- 01/21/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
- 01/23/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
- 01/23/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.

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---01/24/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/25/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/25/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
 ---01/26/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
 ---01/26/18 7:00 p.m. to 7:00 a.m. two (2) staff members needed.
 ---01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/27/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/28/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/28/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---01/29/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
 ---01/29/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
 ---01/30/18 7:00 a.m. to 7:00 p.m. two (2) staff members needed.
 ---01/30/18 7:00 p.m. to 7:00 a.m. one (1) staff member needed.
 ---02/03/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.
 ---02/04/18 7:00 a.m. to 7:00 p.m. one (1) staff member needed.

During the tour, all units were found to be staffed per facility policy. All units were clean and tidy, chairs were found to be light weight and easily movable. All beds were found to be made of heavy materials. All door hardware and bathroom fixtures were anti-ligature. There were no shower curtains or rods. All doors to patient rooms were locked. Doors to bathrooms and patient rooms were slanted to diminish ligature potential. All doors exiting the units were locked. Patient rights were posted in the day rooms.

Review of facility policies and procedures included but was not limited to the following:

1. Patient Rights, effective date of 01/17, with a reviewed date of 01/18, revealed that the policy is to ensure that all patients receive a copy of the Patient's Bill of Rights and Responsibilities form, as well as an oral explanation of those rights, both in their primary language and in simple non-technical terms.

The procedure is as follows:

---Prior to admission, each individual shall be provided with a copy of the Patient's Bill of Rights form and a verbal explanation to those rights in their primary language in simple non-technical language. The minor's parent, managing conservator or legal guardian will be given the patient's Bill of Rights form. The information is provided in a manner tailored to the patient's age, language, and ability to understand.

---A copy of the Patient's Bill of Rights form shall be displayed prominently at all times in each of the following locations: waiting room and lobby areas, cafeteria, dayrooms, recreational rooms, and any other areas frequented by persons receiving services. Copies shall also be available at these locations to anyone requesting a copy.

The summary of Patient Rights and Responsibilities lists the following:

---To provide care and treatment that is respectful, recognizes a person's dignity, cultural value and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment.

---To be free of abuse and neglect.

---Care delivered by the health care entity in accordance with the needs of the patient.

---To receive care in a safe setting.

2. Assessment/Reassessment by RN, effective Date of 01/17, with a reviewed date of 01/18, revealed the following procedure:

---The RN completes the RN Assessment within 8 hours.

---Formulates a nursing care plan including a discharge plan.

---Reassesses the patient every shift and whenever the patient's bio-psychosocial status or precautions level changes; within 72 hours of admission; every thirty minutes if a patient is in restraint or seclusion, and if a patient is identified to have a physical complaint.

3. Staff Assignments, effective date of 01/17, no revision or review date noted, revealed the purpose is to ensure safe practice and quality patient care.

---All clinical staff shall be competent to fulfill their assigned responsibilities.

---Job descriptions shall be written to clarify role, responsibilities and qualifications necessary to carry out the role.

---All newly employed staff shall complete orientation before assuming responsibilities for patient care.

Assignment of patient care staff shall include the consideration of:

a) Patient condition and care requirements.

b) Patient acuity and stability.

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- c) Complexity of patient assessment.
 - d) Degree of supervision required by staff.
 - e) Infection control and safety issues.
 - f) Environment in which the nursing care is provided.
- The charge nurse will complete staff assignments.

Review of the Nurse Staffing Plan revealed that care is provided by a team of RNs, LPNs, and MHTs. Employees will have documented competence and orientation specific to the care of the patient population being served. The core staffing level is projected based upon the following critical factors:

- patient characteristics and number of patients cared for including admissions, discharges and transfers.
- intensity of patient care being provided and the variability of patient care across the unit.
- scope of services provided, architecture and geography of the unit.
- characteristics of the staff including: consistency and tenure, preparation and experience, the number and competencies of clinical and non-clinical support staff the nurse must collaborate or supervise.

The CNO meets with Charge Nurses from each patient care area daily (Monday-Friday) to evaluate staffing needs and make appropriate adjustments in the number and blend of nursing care personnel to ensure delivery of optimal patient care using the daily staffing plan.

The core staffing plan will be evaluated and recalculated at least annually or as necessary. This evaluation will utilize one of each of the following three types of outcomes:

- Patient outcomes that are nursing sensitive such as; patient falls, adverse drug events, injuries to patients, skin breakdown, pneumonia, infection rates, cardiac arrest, length of stay or readmissions.
- Operational Outcomes such as work-related injury or illness, vacancy and turnover rates, nursing care hours per patient day, on call agency use, or overtime rates.
- validated patient complaints related to staffing levels.

Nurses that have concerns related to staffing shall report their concerns timely according to the hospital's human resources policies. There shall be no retaliation for reporting concerns. The committee responsible for developing, monitoring and evaluating the plan to address these concerns. This feedback will be reported back to the nurses who raise the concerns.

4. Observation levels, effective date of 01/17, with a reviewed date of 01/18, revealed it is the policy of the facility to provide a safe and secure environment for patients during their hospitalization. Special precaution procedures can be initiated by physician or nursing staff when a patient may be an increased risk for harm to self, others or property, or for those patients who need an increased level of observation and precaution for other reasons. The nurse or physician should determine the level of risk associated with each new admission and throughout their hospitalization. A rounds sheet must designate special observations on the patient. Precaution Levels are as follows:

- One to One guidelines maintain that the patient is monitored by 1:1 staff ratio at all times, within reaching distance at all times. Patient Rounds Sheet (PRS) which reflects the patient's location and observed behaviors every fifteen minutes is maintained at all times.
- Constant Observation (Line of Sight) guidelines maintain the patient in visual range of assigned staff at all times. PRS is maintained at all times.
- Close Observation guidelines maintain PRS is maintained at all times.

5. Documentation Observation Sheet Guidelines, effective date of 01/17, with a revision date of 02/18, revealed the following information shall be documented every fifteen (15) minutes as appropriate

- Patient's exact location
- Pertinent descriptions of patient's current condition, behavior or activity
- Significant patient responses to the care provided by the staff
- Time that precautions were implemented and discontinued

The staff member assigned to do the fifteen (15) minute checks and/or 1:1 on a patient shall be responsible for documenting on the Documented Observation Sheet. If the patient is off the unit or in a group activity, documentation on the Documented Observation Sheet shall be performed by the staff member who is with the patient.

6. Grievances and the Patient Advocate, effective date of 01/2017, with no revision or review date, revealed the facility will provide an effective mechanism for handling patient, family, guardian, patient's representative and/or patient's surrogate grievances as an important part of providing quality care and service to our patients.

The procedure is as follows:

- The patient and others are informed of the patient's rights and responsibilities upon admission, and the

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process by which they can voice any concerns related to their rights and/or treatment. This information includes the name of the patient advocate, and the method of access to the patient advocate. The patient advocate's name and phone number are also posted in the lobby and on the unit.

---When a patient voices a complaint, the patient may be encouraged to discuss the complaint with their physician or unit nursing staff.

---If the issue cannot be resolved at this level (or if the patient wishes to contact the patient advocate directly), the patient will have access to the Patient Advocate/designee to facilitate resolution of the grievance. An issue becomes a grievance if it involves an allegation of abuse or neglect, a patient's right violation, or it can't be resolved prior to discharge. A grievance must be filled within a reasonable timeframe, and no later than sixty (60) days following the occurrence. Receive care in a safe environment and be free from all forms of abuse and harassment.

--- Each patient and all making a complaint will receive a response from the facility staff that addresses the complaint in a timely manner (with-in one week). The response should be written on the complaint form and signed by the patient. If the patient is no longer at the facility the response should have a response letter sent to the last known address. The written response is to be provided with-in thirty (30) days of the filed grievance.

--- Complaints received in written form should be forwarded directly to the chief executive officer (CEO) or designee who should delegate investigation to the appropriate staff members.

---Any written responses to patients and /or family members should be reviewed by the CEO or designee prior to being sent.

---The patient advocate will investigate all complaints received from patients and others, as appropriate responds to patient/family grievances promptly.

7. Medical Emergencies, effective date of 01/2017, with no revision or review date, revealed that the facility will provide basic first aid, basic life support, and notification to emergency services in the event of an unexpected illness or injury in a patient, visitor, staff member, or any other person to the extent that the equipment and expertise will allow the facility at the time of the event.

The procedure is as follows:

---The staff person witnessing or receiving an initial report of an illness, accident, or injury requiring emergency response will activate the emergency by calling a "Code Blue" over the paging system.

---All patients will be examined on the inpatient unit, if possible.

---The nursing supervisor/designee will respond to the site with the emergency cart.

---Other individuals may respond as they are available which may include, but not be limited to: any physician in the building and all available nurses.

--- Nursing and/or medical staff, will determine the nature of the medical emergency and, if a patient of the hospital, contact the internal medicine group, the attending physician and/or the on-call physician for medical orders.

---If the life-threatening emergency exists, basic life support measures will be initiated and a 911 call placed to activate the Emergency Medical System.

--- Available staff not engaged in the medical emergency will make copies of appropriate portions of the medical record to send to the hospital with any patient requiring transport to an Emergency department.

---A patient status report will be called to the Emergency department of the receiving hospital. Once the medical emergency has been addressed, a Memorandum of Transfer will be prepared and forwarded at the first available opportunity.

---Employees requiring medical care will be subsequently referred to the Director of Human Resources, if possible, to review the need for workman's compensation services.

---Other individuals requiring non-emergent medical care will receive a recommendation to contact their primary care provider.

---An incident report will be completed documenting details of any event.

During an interview on 03/12/18 at 12:30 p.m. in the Conference Room, the DRMPI (#2) explained that patients receive a copy of their patient rights upon admission and that patient rights is posted on every unit in the Day Room. The DRMPI said that patients and/or their representative sign the consent for treatment, receive Advanced Directive information as requested, and are informed of how to file a grievance. The DRMPI confirmed that staff receive CPI training upon hire and annually. In addition, he/she explained that Quality Data reports are reviewed and tracked for any trends. In addition, he/she explained that a new system was being presented to the Corporate Office later this month and that the new system provided a severity level to all occurrences. The DRMPI confirmed that there were no complaints lodged by any of the 10 sampled patients as listed above (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10).

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During a second tour of the facility with the CNO on 03/12/18 at 1:10 p.m., the CNO (#1) explained that the facility had already identified that the chairs on the units were light and was in the process of getting heavier chairs. In addition, the CNO explained that the facility was also going to be changing out the hand sanitizers because the hand sanitizers at present are metal and the facility is going to safety hand sanitizers.

During an interview on 03/12/18 at 4:00 p.m. in the Conference Room MHT #9 stated he/she has been at this facility since 01/09/17 when the facility opened. He/she explained there had not been a lot of staff turnover. MHT #9 said he/she works on the adolescent unit and that rounding is done every 15 minutes, but sometimes sooner to keep the patients off guard. Staff #9 said that he/she was trained to do rounding this way. MHT #9 confirmed that he/she was on duty the day that the patient hung him/her self, and that the Nursing Supervisor (#3) went over to the unit where this patient was located. MHT #9 stated he/she thought the ratio on the unit was 1:7. The MHT said that today there were 19 patients on the unit with 3 RNs and 2 MHTs. MHT #9 said the RNs do help monitor patients. He/she said today "I have 11 patients and the other MHT had 8 patients" but the nurses help with monitoring. MHT #9 confirmed that he/she is aware to contact the Nursing Supervisor with any staffing concerns and of the Human Resources (HR) policy on contacting HR regarding staffing issues.

During an interview with LPN (#4) on 03/12/18 at 4:35 p.m. in the Conference Room, the LPN said he/she has been a nurse since 1994 and has been at this facility for five (5) months. The nurse said staffing could be better. He/she stated, I came in during a hiring wave (lot of new employees). The LPN explained that there has been a change in management recently. The LPN stated the units are normally staffed on a 1:5 ratio. The LPN said that MHTs and nurses monitor patients. The LPN explained that the facility had recently started adding a second person to help monitor patients in groups. The LPN confirmed that he/she was the staff member that had been hit in the face with a chair. The nurse explained that acuity on that unit had been high that night and that staffing could have been better. The LPN said that he/she thinks the new CNO walked into a hell storm, and that he/she (LPN) feels that the staffing is better since the new CNO has arrived.

During an interview with (b)(6) (b)(7)(c) (#10) on 03/13/18 at 10:30 a.m. in the Conference Room, the Director explained that he/she had been at the facility for five (5) months. He/she explained that prior to the hanging incident he/she had adjusted all patient bathroom doors so that they close for privacy but do not latch. He/she stated the facility had two (2) bids out to get all patient bathroom doors lowered. The Director explained that even though the bathroom doors are slanted the facility decided to lower the doors to prevent any items from being able to catch in the corners next to the hinges.

During an interview on 03/13/18 at 12:00 p.m. in the Conference Room, Nursing Supervisor (#3) stated he/she started work at this facility when the facility first opened. The Supervisor confirmed that he/she was the supervisor on duty at the time the patient hung himself/herself (patient #1). The Supervisor explained that the Supervisor's role is to cover the entire house. He/she explained that the patient hung him/her self on a Saturday after visiting hours. The Supervisor went on to say that on that day (01/20/18) there were a couple of psychiatric codes with patients on the acute unit. The Supervisor explained that he/she had just left the acute unit and had gone to his/her office at the end of the hall on the acute unit when he/she heard the code blue page to respond to the adult intermediate unit. The Supervisor said that when he/she arrived a staff member was performing cardiopulmonary resuscitation on the patient. The Supervisor said that he/she ran and called 911, returned to the room and began to bag the patient as the crash cart had arrived while he/she had gone to call 911. The Supervisor said that EMS arrived and hooked the patient up to their (EMS) monitor and that the EMS reported that the patient's heart rate was in the high 100s (normal 60-100). The Supervisor confirmed that the unit had been staffed with two (2) RNs, one (1) MHT at the time, and one (1) Security Officer who was monitoring a patient 1:1. The Supervisor confirmed that Supervisors adjust staffing on the weekends according to the census on the units and patients' acuity, and for any special observation status that is ordered.

Eleven out of eleven personnel files revealed that there was current crisis prevention intervention (CPI) training per facility policy. The facility utilized the following nursing positions for patient care:

1. Nursing Supervisor Position Summary: The role is responsible for ensuring delivery of patient care consistent with the established standards of care of mental health practice and hospital policy, goals and objectives.

Qualifications: Graduate of an accredited school of nursing required or equivalent combination of education of education and experience in psychiatric nursing experience management. An experience level of three (3) years' experience in a psychiatric health-care facility. Additional requirements include a CPR certification and successful completion of the CPI training within 90 days of employment.

Standards of Performance: Include, leadership, personnel management, treatment planning, teaching, milieu (personal environment) management, clinical intervention, clinical assessment, performance management of

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employees as assigned and specific standards of care for adult patients ages (b)(6) (b)(7)c years and older, care of chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

2. Staff Nurse (RN) Position Summary: A RN who prescribes, coordinates, and evaluates patient care by working together with health care team according to nursing process and standards of care practices. Qualifications: Graduate of an accredited school of nursing required or equivalent combination of education and experience in psychiatric nursing; three (3) years' experience in a psychiatric health-care facility is preferred. Additional requirements include a CPR certification and successful completion of CPI within 90 days of employment and prior to assisting in restraining patients.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations and risk management. Specific standards of care for children ages (b)(6) (b)(7)c geriatric patients ages (b)(6) (b)(7)c older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

3. Staff Nurse (LPN) Position Summary: This position is a LPN who assists in providing nursing care with a health care team according to nursing process and standards of care practices. Qualifications: Graduate of an accredited LPN program is required. Three (3) years' experience in a psychiatric health-care facility is preferred. Additional requirements include a CPR certification and successful completion of CPI within 90 days of employment and prior to assistance in restraining procedures.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations and risk management. Specific standards of care for children ages (b)(6) (b)(7)c geriatric patients ages (b)(6) (b)(7)c older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

4. MHT Position Summary: Functions as an active part of the treatment team, providing continuous patient care, supervision, interaction and role modeling to patients ranging in age from pre-school through geriatrics depending on which units worked. The MHT works under the direction of an RN.

Qualifications: A CPR certification and successful completion of CPI within 90 days of employment and prior to assistance in restraining procedures.

Standards of Performance: Include assessments, interventions, treatment planning, milieu (personal environment) management, clinical intervention, clinical assessment, teaching, infection control practices, risk management, Occupational Safety and Health Administration (OSHA) regulations. Specific standards of care for children ages (b)(6) (b)(7)c geriatric patients ages (b)(6) (b)(7)c older as well as standards for the care chemically dependent patients. Ability to meet physical and mental requirements as set forth by the facility as well as use of machines, tools and equipment and other work aides identified by the facility as necessary for patient care.

Review of the facility's staffing from 03/04/18 through 03/10/18 for a total of 14 shifts revealed the following:

- Adolescent unit was staffed appropriately per facility policy for census and acuity.
- Adult Intensive Care Unit was staffed appropriately per facility policy for census and acuity.
- Adult Intermediate Unit staffed appropriately per facility policy for census and acuity.
- Senior Unit staffed appropriately per facility policy for census and acuity.

On 03/13/18 at 4:30 p.m. the facility's corrective actions were reviewed. The corrective actions that were put in place prior to the survey included the following:

1. Attempts to obtain a copy of the acute hospital's medical record were refused due to the facility's inability to get a release of information from the family.
2. Attempts to get a copy of the Georgia Bureau of Investigation's autopsy report were still in progress as the report was still pending.
3. The CEO hired a new CNO on 02/14/18, the new CNO started a little over two (2) weeks ago.
4. The CEO hired a new Director of RM/PI.

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5. Staff that were found to not be following facility policy were terminated.
6. The facility has hired three (3) new RNs and seven (7) new MHTs. The CNO confirmed that he/she is still interviewing and had two (2) RNs interviews today.
7. Brought personal alarms that attach to employee name badges. These alarms can be used to signal for assistance by emitting a shrill alarm when activated. The CEO explained this will prevent staff from having to leave a patient to get help. The CNO stated 80 percent of employees have the alarms and another shipment is scheduled to arrive 3/14/18 to ensure that 100 percent of staff have the alarms.
8. In-services provided by the CNO at the Town Hall Meeting for staff on 02/27/18, 02/28/18, and 03/01/18 at various times revealed sign-in sheets of attendees. These in-services covered patient safety, every 15 minutes observations, importance of charting observations in real time (pre-or post charting was explained by the CNO to be falsification), Triggers to Look For, and Alternative Crisis Management.
9. Added a column for staff to document hand-off to another staff member on the observation flow sheets.
10. Nursing Supervisor check point for shift assessments/rounds.
11. Overview of orientation, orientation to include patient safety, staff safety, rounding.
12. Developed an Infection Control/Educator position that has been filled.
13. A QA/PI determined overhead page was to be turned up.
14. New policy to keep all patient rooms locked during the day (rooms had been kept unlocked so patients could go to their bathroom) and one (1) hall bathroom is now utilized.

Based on review of the facility's Quality Data, medical records, video recordings, staff interviews, tours, observations, staffing, policies and procedures, personnel files, job descriptions, and the facility's corrective action plan, it was determined that an Immediate Jeopardy occurred from 01/20/18 through 02/04/18. No deficiencies were cited due to the facility's corrective actions which were implemented prior to the survey.

Findings Text:

SURVEY INFORMATION

<u>Event ID</u>	<u>Start Date</u>	<u>Exit Date</u>	<u>Team Members</u>	<u>Staff ID</u>
1YFN11	03/12/18	03/13/18		

(b)(6) (b)(7)c

Intakes Investigated: GA00186067(Received: 03/09/2018)

SUMMARY OF CITATIONS:

<u>Event ID</u>	<u>Exit Date</u>	<u>Tag</u>
1YFN11	03/13/2018	Federal - Not Related to any Intakes A0000-INITIAL COMMENTS

EMTALA INFORMATION - No Data

DEEMED/RO APPROVAL INFORMATION

Ro Request for Approval: 03/09/2018

RO Approval Date: 03/09/2018

ACTIVITIES

<u>Type</u>	<u>Assigned</u>	<u>Due</u>	<u>Completed</u>	<u>Responsible Staff Member</u>
Schedule Onsite Visit	03/12/2018	03/12/2018	03/14/2018	

(b)(6) (b)(7)c

INVESTIGATIVE NOTES - No Data

Printed: 06/20/2018 2:20:30PM

Due Date: 03/13/2018

Priority: IJ

Intake ID: GA00186067

Facility ID: HOSPA0203 / HOSP-PSY

Provider Number: 114037

Mgmt.Unit: HSC

ACTS Complaint/Incident Investigation Report

CONTACTS - No Data

AGENCY REFERRAL - No Data

LINKED COMPLAINTS - No Data

DEATH ASSOCIATED WITH THE USE OF RESTRAINTS/SECLUSION - No Data

Reason for Restraint:

Cause of Death:

NOTICES

Letters:

<u>Created</u>	<u>Description</u>
03/06/2018	ACK- HCS COMPLAINT/Complainant
03/20/2018	ACUTE- COMPLAINT FACILITY UNSUB NO DEF/Facility
03/20/2018	ACUTE- COMPLAINANT CLOSURE- SUBST/Complainant

Notification:

<u>Date</u>	<u>Type</u>	<u>Party</u>	<u>Method</u>
03/06/2018	Acknowledgement to Complainant	Central Office	Written
03/20/2018	Findings Sent to Complainant	Central Office	Written
03/20/2018	Findings Sent to Complainant	Central Office	Written
03/20/2018	Findings Sent to Facility	Central Office	Written

PROPOSED ACTIONS

<u>Proposed Action</u>	<u>Proposed Date</u>	<u>Imposed Date</u>	<u>Type</u>
None	03/20/2018		Federal
Other	03/20/2018		Federal

Closed: 03/20/2018

Reason: Paperwork Complete

END OF COMPLAINT INVESTIGATION INFORMATION